July 11, 2014 –Rough Draft for Provider Q&A

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Health Homes Services

What are the criteria and goals of Health Homes?

Kansas has outlined four goals to assess the effectiveness of our Health Homes program:

- Reduce utilization associated with avoidable (preventable) inpatient stays.
- Improve management of chronic conditions.
- Improve care coordination.
- Improve transitions for care between primary care providers and inpatient facilities.

Can you provide more detail on what the Health Homes is and how it helps individuals?

A Health Homes is not a building, but is a comprehensive and intense system of care coordination that integrates and coordinates all services and supports for people with complex chronic conditions. Health Homes services do not replace existing acute care and long-term services and supports, but are layered over them to ensure well-coordinated care, without gaps and duplicative services. Health Homes will reduce unnecessary hospital stays and emergency room use and engage the member and all his or her providers in coordinated management of the chronic conditions the member has. For more information about Health Homes, please refer to this website: http://www.kancare.ks.gov/health_home.htm.

Define the roles/differences of comprehensive case management and care coordination.

All six Health Homes services are defined in documents found here: http://www.kancare.ks.gov/health_home/providers_materials.htm. The basic differences between these two services is that comprehensive care management involves assessing the member's needs, conditions and existing services, as well as working with the member, family and all providers to create a Health Action Plan. The Health Action Plan details some health goals and outlines who is responsible for each action step for each goal. Care coordination involves the ongoing implementation and monitoring of Health Action Plan to ensure that all action steps are being taken and, as goals are achieved, new ones are set.

What will these individuals receive that the rest of the population does not?

Please refer to the two questions immediately above.

What are the "new" services definitions the State will create if the HH services are different from KanCare? (behavioral health)

The Centers for Medicare and Medicaid Services (CMS) requires HHs to provide six core services. These are:

- Comprehensive care management.
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support
- Referral to community and social supports
- Use of HIT to link services

These are the services the State must define and has done so. See the draft services definitions document here: http://www.kancare.ks.gov/download/Health_Homes_Draft_Service_Definitions.pdf

General

What is the outlook for this initiative to be implemented on July 1, 2014?
KDHE fully expects both types of Health Homes, for people with serious mental illness (SMI) and people with asthma or diabetes (Chronic Conditions – CC) to be ready to implement July 1, 2014. *is there more current info?*

What is the "threshold" to initiate Health Homes in Kansas? Is there a certain number of Health Home Partners (HHP) required?
We intend to launch the program July 1, 2014. There is not a specific number of HHPs required. The network must be sufficient to serve the number of people who are assigned and don't opt out.

Who will be responsible, in July, to explain to Medicaid beneficiaries what a Health Home is, answer their questions, and assist them in determining if they want to be a part of this program or opt out?
Everyone who knows about Health Homes and encounters a consumer who has a question – case managers, community providers, MCOs, advocates and State staff.

Will persons with cognitive delays but no mental health or physical health issues be automatically included in the July 2014 group?
No.

What steps should community providers be taking right now?
Learn as much as you can about HHs by going to the KanCare Health Homes web page (http://www.kancare.ks.gov/health_home.htm) and reach out to the MCOs if you are interested in becoming a HHP. You should also talk with hospitals and other providers in your area, so you can begin collaborating with providers who will be providing services that need to be coordinated by HHs. You can sign up for the Health Homes Herald, our monthly newsletter, which will help to keep you informed, by sending your information via the healthhomes@kdheks.gov e-mail. In the newsletter, you'll find announcements of any state-sponsored meetings or presentations that may be occurring in your area about Health Homes.

How is Health Homes any different from the promise of KanCare, better coordinated care=better health outcomes for all people? Isn't this an admission that regular KanCare doesn't work?
A Health Homes is even more intensive care management and care coordination that focuses on members with certain chronic conditions. Not everyone in KanCare will have a condition that requires a Health Homes. Health Homes were always included as a component in KanCare, but were not intended to launch until the second year of KanCare.

What is the difference between Health Homes and NFMH? It sounds the same.

A Health Homes is not a residential setting, nor is it all services provided by a single provider. It is a comprehensive and intense system of care coordination that integrates and coordinates all services and supports for people with complex chronic conditions.

When will the list of organizations contracted to be a Health Homes be available to the public?
KDHE will begin publishing this information in June 2014, although the MCOs will report to KDHE on their HHP network development every two weeks, beginning April 15, 2014.

When will we know who the individuals are that have been targeted for the SMI Health Homes?
We hope that Health Homes Partners will know of potential enrollees in late fall, but official notifications will go out in January to the enrollees and the HHPs.

How will we know who we are the HHP for, and how will the consumer choice work?
The MCOs will notify you as they send out the assignment letters and then will update your list as they receive the opt out information from the State. Members can choose to opt out of Health Homes at any time. They can also choose a different HHP at any time. To opt out, they need to contact Hewlett Packard Enterprises (HP). To opt back in, they will contact their MCO. To choose a different HHP, they will contact their MCO.

Is both Medicaid and CHIP included in the program?
No. The Federal statute authorizing Health Homes only authorizes funding for people who are eligible for Medicaid.

Is the Health Homes program for adults and children?
Yes, if they meet the target population criteria, both adults and children are included, but only children who are Medicaid (Title XIX) eligible. Children in the Children's Health Insurance Program (CHIP – Title XXI) are not eligible since Health Homes is a Medicaid program.

Are children included in the Health Homes program or what ages are being considered for this program?
Any child who meets the definition of having a serious mental illness, outlined in the SPA (found here: http://www.kancare.ks.gov/health_home.htm), or who has a chronic condition outlined in the second SPA will be offered a HH. Since both diabetes and asthma will be included in the second SPA, there will be a significant number of children eligible for HHs.

Medicaid patients often use Hospital Emergency Departments because they are unable to quickly access services in the community. How do you see the Health Homes program helping with access to primary care (medical) and mental health services (i.e.: medication appointments, psychiatric services, case management)?
Our hope is that Health Homes will work to help build more collaborative relationships among community health care providers that will result in Health Home members having primary care that is more accessible.

Please explain the relationships and delineation of "Lead Entity", "Health Home Partner/Provider", and "Subcontractor".
The Lead Entity is one of the three KanCare managed care organizations (MCOs). It is responsible for developing a network of Health Home Partners – HHPs – (who are community providers, e.g. physicians, clinics, Community Mental Health Centers) who can provide some or all of the six core Health Home services. The HHPs can subcontract with one or more agencies/people to provide one or more of the six core services. The HHP must contract the Lead Entity and must meet the requirements specified in the State Plan Amendment (SPA) and the Program Manual (found here: http://www.kancare.ks.gov/health_home/providers_materials.htm). Any subcontractor would work with the HHP and would not necessarily have to meet all the requirements, but if they were providing a specific core service, would need to meet the professional requirements for the service.

How will HHP representatives interface with MCO Care Coordinators? Who is "in charge"?
Given that HHs are to be person-centered, the person is in charge. Whichever half of the HH (MCO or HHP) provides care coordinated and all providers involved are communicating with one another.

Will Community Mental Health Centers be the only entities contracted to provide behavioral health HH services? Or will other behavioral health providers offering MH/SUD services be able to Partner for HH services?
No, although we encourage all CMHCs to become HH Partners since they are well-placed to serve the SMI population due to their expertise. Additional providers can become HH Partners if they meet the standards and qualifications and are willing to contract with the MCOs.

How would this be different than a Home Health Agency providing services?
Home Health agencies typically provide nursing care for therapies in the individual's home under a plan approved by a physician. Health Homes services are not necessarily provided in the home, although KDHE expects that care coordination be

provided mostly in-person, when the care coordinator is working with the member. Much of what the six core Health Homes services will do will not even be known by the member, since the services will occur between providers and community and social services organizations.

How do we all fit together to form a Health Home?
That will vary, depending upon whether the Lead Entity is providing some of the six core services. If the Lead Entity does none of the six services, they would identify and assign the member and then the HHP would be responsible for the six core services, either directly or through a subcontractor. Whoever is responsible for comprehensive care manage would work with the member, he members' providers and family to develop a Health Action Plan. The care coordinator, most likely at the HHP if the Lead Entity is not performing any HH services, would then manage and monitor the HAP to make sure all assigned parties are working toward the goals laid out. Whoever is doing Health Promotion would work to make sure the member is getting education about their chronic conditions and what they can do to better manage them and be healthier. Each service is defined in great detail in the State Plan Amendment and Program Manual, found here: http://www.kancare.ks.gov/health_home/providers_materials.htm.

Can HH Partners contract services out?
Yes, but they will need to be responsible for meeting the qualifications and standards outlined in the SPA. They could meet some of those through contracting out, but they will be held accountable by the MCO in the contract between the MCO and the HHP.

Will there be more than one Health Home in a community?
There must be a choice of Health Homes in an area. The MCOs/Lead Entities and their Health Home Partners (HHPs) will determine what an "area" is.

So, it looks like there could be multiple HHPs in a given geographic region, all competing with one another, but also perhaps all engaging in contracts with one another for specific services?
In order to provide members with a choice of HHPs, as CMS requires, there must be at least two HHPs available in each county. There is nothing to preclude HHPs from contracting with each other to provide some HH services, but they would not be required to do so.

Do you have any guidelines regarding the ratio of members to specific providers in a Health Homes , i.e. 500 members per RN at a CMHC?
No, although the actuaries are using some assumed ratios to help build the rate the State will pay the MCOs for HHs.

If there is only one Partner in the area who wants to be a HHP, how will other gaps get filled?
The Lead Entity will either need to recruit another HHP or be ready to provide the Health Homes services directly.

How will the customers know about Health Homes and what they provide?
The State is working on some communication materials that we will share soon with providers to help them educate consumers. We will also hold some consumer meetings across the state to talk with consumers, help them understand HHs and answer their questions.

What is the hospital's role in Health Homes?
Medicaid-funded hospitals in the state are required to work with Health Homes in the following ways:

- Hospitals must refer individuals who are likely to meet the minimum eligibility requirements to a Health Homes.
- Hospitals must communicate with Health Homes regarding ER and admission discharges.
- Some HHPs may want to enter into formal agreements with hospitals to ensure cooperation and provision of services.

Can the potential Health Homes Provider's contract with MCOs past the 1/1/14 date? (For example, could HH Partner "A" contract with MCO-Y on 11/15/13 and MCO-Z on 2/15/14?)
Yes.

How do we become a Health Homes/Health Homes Provider? Does every provider have access to a Health Homes? If not, what are the qualifications?
The requirements to be a Health Homes Provider (HHP) can be found in the documents found here: http://www.kancare.ks.gov/health_home/providers_materials.htm. In order to become a HHP, you must first complete the Preparedness and Planning Tool (PPT) found at the aforementioned link. You must also meet all the requirements outlined in the documents contained at the link and you must be willing to contract with at least one KanCare Managed Care Organization (MCO) and at least one MCO must be willing to contract with you.

Preparedness & Planning Tool (PPT)
Is there flexibility in the timeline to get applications in?
Yes. Though agencies interested in becoming a HHP were encouraged to submit the Tool by April 1st, we will continue to accept Tools.

What if we have additional information to add or clarify on our previously submitted Preparedness Tool?
Please contact Samantha Ferencik at sferencik@kdheks.gov to discuss your desired changes/additions.

Are agencies who want to subcontract for services expected to complete the PPT?
Yes. All agencies who hope to provide any of the six Core Services should complete the Tool.

How much of the Tool would a subcontracting Targeted Case Management (TCM) provider (I/DD) complete?
TCM providers are not required to complete the Tool. However, if you choose to complete the Tool, you only need to complete the portions that are specific to the Core Services you intend to provide.

Can the language line be used to meet the requirements/accommodations related to culture, disability, language etc.?
Maybe. Please feel free to include as much detail as you desire. The MCOs will assess your explanations to determine if the requirements are met in full or in part.

Member Assignment & Referral

Eligibility

Please clarify the date that members become eligible for the Health Homes program.
For the launch, everyone identified by the MCOs/Lead Entities as eligible will receive assignment letters the first part of July 2014. If they don't opt out, their services will begin August 1st, 2014. (They can opt any time, even after August 1st.) Thereafter, the Lead Entities will mine their data monthly and take referral information, sending out assignment letters monthly to newly identified members. Services will start in the month following the assignment letter.

Do you have an estimate of the number of persons eligible by county?
You may contact Dr. Theresa Shireman for the information, provided the number is large enough to avoid a violation of HIPAA. Her e-mail is tshireman@kumc.edu.

Is a patient eligible for Health Homes when Medicaid is secondary?
Yes.

Are veterans or those who have services through the Veteran's Administration eligible for Health Homes?
Only if they are also eligible for Medicaid.

Can these services be provided in long term care facilities?
No.

Will persons with cognitive delays but no mental health or physical health issues be automatically included in the July 2014 group?
No.

What does "QMB" stand for? Are these members eligible for Health Homes?
A Qualified Medicare Beneficiary is someone who has Medicare coverage and qualifies for Medicaid to pay for their Medicare premiums and co-pays. They are not eligible for Health Homes.

Are youth in the Home Community Based Service (HCBS) Waiver for Severe Emotional Disturbances (SED) also eligible for Health Homes?
Yes, because being on the waiver makes them eligible for Medicaid, but they still must meet the Health Homes eligibility criteria.

Does the Health Homes model apply to Work Opportunities Reward Kansas (WORK) participants? If so, will Independent Living counselors be included as Partners?
Yes WORK participants can be eligible for Health Homes if they meet the target population criteria. ILCs will continue to provide the same services to WORK participants who are also in Health Homes.

How will FMS services be used by those in the Health Homes Service Model?
In-home services, provided to people on home and community based services (HCBS) waivers, and authorized through an electronic visit verification or financial management system called Authenticare, will continue to be provided to Health Homes members. Health Homes services are in addition to regular KanCare services.

Will a Health Homes be a substitute for residential home services?
No. A Health Homes is not a place for someone to live, it is a set of services intended to provide intense and focused coordination of other physical, behavioral and long-term supports and services so the person's health outcomes will be improved.

-Where are the terms "chronic" and "serious" conditions clearly defined?
-What is the definition of Serious Mental Illness (SMI) when it comes to those qualifying for Health Homes?
-For the purpose of Health Homes, how is serious & persistent mental health conditions being defined and will it be consistent with the definitions found in the CMHC contract?
-Who defines member eligibility-KDHE/KDADS or the MCOs?
-What is the definition you are using for SMI? And does it include children?

Those two terms are used in these ways:

1. The ACA spells out broadly who can be a Medicaid HH by stating the person must have either two chronic conditions or one condition and be a risk for another, or have one serious and persistent mental illness. The ACA then lists a few conditions and notes the Secretary of Health and Human Services can approve others. Generally, chronic means a condition that is long-lasting, not likely to be cured, but able to be managed.
2. Kansas is defining "one serious and persistent mental illness" as having one or more diagnoses from this list:
   - Schizophrenia
   - Bipolar and major depression
   - Child disintegrative disorder
   - Delusional disorders
   - Personality disorders
   - Psychosis not otherwise specified
   - Obsessive-compulsive disorder
   - Post-traumatic stress disorder

Is there a decision tree or formula for making the HH determination?
No, the determination will be made based on mental health diagnoses codes. See above.

Will the State identify the qualified candidates or like WA - will KS send the file to MCO?
MCOs will identify potential HH enrollees based on the diagnoses codes above.

Does SMI include SPMI and PRS clients?
It includes anyone with one or more of the diagnoses listed above.

Many consumers with I/DD have SMI diagnoses. Will they be included in the SMI Health Homes?
Yes. Anyone with one or more of the listed diagnoses is a potential HH enrollee.

Could eligibility criteria include a physical condition and Serious Mental Illness diagnosis such as diabetes and depression?
The eligibility criteria for both Health Homes are described in the numerous documents found here:
http://www.kancare.ks.gov/health_home/providers_materials.htm.

Will KS be using the CMS SMI definition as opposed to the current KS SPMI definition to determine the MH population needing to be identified?
The State has defined serious mental illness as a person who has one or more diagnoses listed in the SPA posted here:

http://www.kancare.ks.gov/health_home.htm. States can define their HH target population how they want, within the limits of the language regarding HHs in Section 2703 of the ACA.

Would a person with only a chronic physical (but no mental illness) be served by a CMHC who is a HHP?
They could be only if the CMHC meets all of the standards and qualifications for Health Homes Partner (HHP) under the second State Plan Amendment (SPA) for people with diabetes or other chronic conditions and it contracts to be a HHP with one or more MCO/s. The person would also have to be assigned to the CMHC by their MCO and choose not to change to a different HHP.

How does having two separate SPAs facilitate the goal of integrated behavioral and physical health?
It is expected that the target population defined in the second State Plan Amendment (SPA) will be much larger than the SMI population and require a broader range of providers to serve as HH Partners. Integration of behavioral and physical health care will still be required for that population as well. That does not mean that everyone must have the same type of HH Partner.

Is there or will there be a list of qualifying diagnostic or DSM-5 codes?
Yes. They are found here:
http://www.kancare.ks.gov/health_home/providers_materials.htm.

Is COPD considered an asthma related complication?
It might be, depending upon what other clinical indicators there were.

Can a consumer's level change during the month?
Not usually, unless there was an error in eligibility that is corrected and usually those take effect the next month.

Is there an appeals process if we disagree with the level?
No. The level is directly related to the member's eligibility category and age. If you believe there is a mistake in eligibility, you should notify the Lead Entity/MCO who will work with the State's enrollment broker and State eligibility staff to see if there needs to be a correction.

Provider Limitations for Service Populations
Has the State set a requirement as to a percentage of the population to be in a HH?
No. We know there are about 36,000 people who would be eligible for the SMI HH, but we don't know how many will opt out. We don't have an estimate for the second SPA related to the other chronic conditions since we are still determining

what conditions will be included. We cannot require people to remain in HHs so there is not a benefit to setting an expectation for HH membership.

How large will the HHP capacity have to be? Are there limits?
It needs to be large enough to be financially sustainable.

Can services be provided "in house" or to community as a whole?
If you mean that you, as a Health Home Partner would only provide Health Homes services to people who you already provide other KanCare services to, you can specify that limit when you contract with the Lead Entity, but you may not have enough Health Homes members to sustain your HHP business. In addition the Lead Entities want to work with HHPs who will have capacity to take new members.

If we become a HHP, could we be assigned a consumer outside of our "waiver services"?
You can limit your membership to people who are already serving in other KanCare services, but please see the caveats listed in the answer above.

Assignment
Will the Lead Entities make HHP assignments according to their diagnosis?
Yes, that is how the Health Homes target population is determined.

Do the claim forms/info that the MCOs receive include all diagnoses or just primary? If just primary, do all patients with a qualifying SMI secondary diagnosis need to be referred to a Health Homes?
KanCare claims contain 10 diagnoses code fields. Any that have been populated by the billing provider will be in the Lead Entities' data and will be used.

What happens if an individual who qualifies for both the Serious Mental Illness & Chronic Condition Target Populations?
That person would be able to choose between the two types of Health Homes, although the Lead Entity will default assign them to the type they believe best meets their needs.

What happens if an individual has three current providers and the HHPs? How is the assignment chosen?
The Lead Entity/MCO will look at all the claims and determine the best HHP from the information they have. The member can always select a different HHP.

If an assignment of Health Homes is in place for someone and then they are determined I/DD, will an I/DD agency become a choice for care coordination services?
The Lead Entity/MCO will likely not change the HHP assignment unless the member

requests it. The member can request an I/DD Target Case Manager (TCM) provider to become part of the Health Homes team and the HHP would have to contract with the TCM provider the member chooses.

What happens if the member "fired" the service provider, does that automatically impact the Health Homes assignment?
If the service Provider is also the HHP, the member could have to select another HHP and work through the Lead Entity/MCO to do so.

When will members receive their health home assignment letter?
For those who will be in the July 2014 launch, they will see a letter sometime in the first week of July.

Who are the HHP assignment letters being sent to?
The KanCare member.

Once the Lead Entity identifies members who qualify for Health Homes and sends them a letter, will they also notify that member's current providers (including the TCM provider, Parent/Guardian, Behavioral health, etc.)?
The Health Homes Partner will receive notification from the MCO of all members assigned to them. It is the responsibility of Health Homes Partner to engage other providers as needed to participate in the coordination of care and services. The member (parent/guardian for children) will receive an assignment letter from the MCO.

Some individuals with intellectual/developmental disabilities may not be able to fully understand the content of an assignment letter. If a guardian is not in place, who decides if they go into a Health Homes?
The member still must make the decision, by Federal regulation. People who support that member – family, friends, and service providers can help them understand their choices.

To be in a Health Home will a client have to sign releases of all the people we are to coordinate with that would not be covered by HIPAA (family, significant others, etc.)?
Only if it is required by federal or state statute or regulation.

Will those assigned to a HHP be listed as such on the Kansas Medical Assistance Program system?
Yes.

If members choose to change their Health Homes, will this be done at the 1st of the month?
Yes.

"Opt Out" Option

Will the benefits of participating in Health Homes and the "opt out" option be clearly explained to members?

Assignment letters and other consumer information is all crafted at the 6th grade reading level, by Federal requirement, but everyone who works with or supports or interacts with members has an obligation to help them understand the information.

Do you have an anticipated opt out rate of members?

25%

Can the HHP apply a waiting period to re-enroll members who opt in and out frequently?

No. CMS has been clear that we cannot restrict members in these choices.

If a client opted into one of the Health Homes programs and did not like it would they be allowed to opt out?

Yes. Members can opt out at any time and can also opt back in at any time. Members who opt out, will be reassigned annually by the MCOs to a Health Homes, but can opt out each year.

If a person is in a NF/MH and they opt out of HH, will they lose their benefits?

No.

Referral

Who is eligible to refer to Health Homes?

Anyone who interacts with a member and has some knowledge about their conditions. The Lead Entities (MCOs) may ask for supporting documentation once a referral is received.

Who will identify those individuals needing a Health Homes?

The MCOs will identify and tentatively assign people to HHs, based on the criteria laid out by the State. Hospitals will also refer people that they see in their ERs to HHs if they believe they may be eligible.

When would a hospital or other entity make referral to a Health Homes?

Any time they see a person who they believe meets the criteria. They should ask them and look them up in the KMAP system to determine if they are already in a Health Homes.

How do we differentiate with patients if they are opting out of a Health Homes?

The Lead Entity/MCO will let you know who has opted out.

When we receive a referral, will we know the level?
As members are assigned to Health Homes Partners (HHPs), the Lead Entities/MCOs will also indicate the reimbursement level for each.

Can a HH decline to enroll a person referred by a MCO?
No. One of the requirements to be a HH Partner is not refusing to serve a referred HH enrollee, except in cases where the safety of the enrollee or Health Homes staff is at serious risk.

Reasons for Refusal
Do the reasons for refusal of member assignment also pertain to subcontractors?
Not necessarily. The Health Home Partner may extend them to subcontractors as part of their agreement with the subcontractors.

Would the following be an example of refusing an individual? A Managed Care Organization attempts to relocate an individual from the Kansas Neurological Institute back into the community. This individual has a respirator and is a brittle diabetic. Could the Community Service Provider for I/DD choose to close or not accept the individual?
If the CSP is a HHP for the Chronic Conditions Health Homes, they could not. If the referral is for the I/DD waiver services, that is a separate issue from Health Homes and would be governed by KDADS.

Enrollment/Disenrollment
Regarding, "members who have been previously discharged with applicable notice in writing", does this include folks written out prior to KanCare?
The Lead Entity/MCO will make the determination based upon what information the HHP provides about the reason for discharge.

Why not have automatic discharge option with catastrophic event?
Each event is an individual situation and sometimes the member may benefit from remaining in the Health Homes.

<u>Payment/Billing</u>
How is the Health Homes program funded?
They are funded with Medicaid funds since it is a Medicaid program. For the first two years the Federal government will pay 90% of the costs and the State will pay 10%. Thereafter the Federal share will be about 60% and the State share will be about 40% - as most Medicaid services are.

How many Health Homes Grants are going to be available? Will they be regional?

There are not grants for Health Homes. MCOs are required to develop networks sufficient to meet the needs of their potential Health Homes members, providing choice of HHPs and covering the state so that Health Homes can be offered statewide.

Who pays for Health Homes services?
The State pays the MCOs a monthly amount to provide Health Homes for each person. The MCOs will sign agreements with different HHPs to help provide health home services. Some of the services will be provided by the MCOs directly and some will be provided by the HHPs. The agreements will say which services are provided by the MCOs and which are provided by the HHPs. They will also say how much the MCOs will pay the HHPs.

How will the payment amount for Health Homes be decided?
Many things will be looked at to help determine the payment. These things may include:

-Staffing Costs -Geographic Variation
-Consumer Needs -Health Home Partner Size

Is a patient eligible for Health Homes when Medicaid is secondary?
Yes.

When will new billing codes and descriptions of codes be sent out so EMRs can be updated for the Jan 1 startup?
There will not be a set of new codes. Health Homes is a bundled service. There will likely only be a single code that will be used to trigger the PMPM for HHs. Providers will be notified of this code as soon as it is confirmed, most likely the first part of September.

Is 'timely filing' involved?
Yes, the same timely filing requirements for all other KanCare services will apply to the Health Homes program. The details of timely filing requirements are outlined in a provider's current contracts with the MCOs and will be outlined in the provider's contract amendment with the MCOs for Health Homes.

Is your first face to face billable?
The delivery of one or more of the six core Health Homes services is billable.

What is the professional licensing required for providing care coordination to qualify as a billable service?
The Health Homes service of care coordination should be provided by the Nurse Care Coordinator and the Social Worker and/or Care Coordinator professionals. The Nurse Care Coordinator is an RN, APRN, BSN, or LPN actively licensed to practice in Kansas. The Social Worker/Care Coordinator must be a BSW actively licensed in

Kansas, a BS/BA in a related field, a Mental Health Targeted Case Manager, an I/DD Targeted Case Manager, or a Substance Use Disorder Person-Centered Case Manager. Case Managers must meet the requirements specified in the Kansas Medicaid State Plan and Health Homes Provider Manuals and can either be employed or directly contracted with the Health Homes Partner.

Will all waiver services (i.e.: waiver facilitation for youth on the SED waiver) be billable?

Yes, with the exception of Targeted Case Management. The Centers for Medicare and Medicaid Services has determined Health Homes Services and Targeted Case Management Services are duplicative. Target Case Managers for Health Homes members on the I/DD waiver are guaranteed a minimum Per Member/Per Month Payment, if the member chooses to maintain the relationship with the Targeted Case Manager, and the Targeted Case Manager provides some of all of the six core Health Homes services. For more information regarding TCM and Health Homes, please see the KDHE's Health Homes Program Manuals: http://www.kancare.ks.gov/health_home/providers_materials.htm.

Does the contracted physician bill independently of the HHP or does the HHP bill for them and then reimburse the physician?

Generally, the Health Homes Partner (HHP) will bill the Lead Entity for Health Homes Services it provides or subcontracts to be provided to its enrolled Health Homes members. Health Homes Services are not billed or paid by the Lead Entity on a fee for services basis. The Health Homes rate is a bundled payment for a bundled set of services, and does not replace any existing KanCare or waiver services, with the exception of Targeted Case Management. More information about Targeted Case Management in Health Homes can be found in the Health Homes Program Manuals: http://www.kancare.ks.gov/health_home/providers_materials.htm.

How is the care provided by a physician as a fee-for-service activity distinguished from the physician's role in the service provided in the HH?

Let's say the member's PCP is also their consulting physician in the Health Homes. The physician would participate in the development of the Health Action Plan. The Health Home member might see the PCP for a physical exam. During that exam, the PCP may refer the member for diabetes education. The PCP would bill for their evaluation and management code. The Health Homes would set the individual up with the diabetes education class and bill for a Health Home service (Health promotion). In a follow up visit the PCP might provide the member some information about the relationship between diabetes and depression. This could be billed as an E&M code or as a Health Homes service (health promotion). Later, the

care coordinator may have a question about how the member is reacting to a medication. The care coordinator could consult with the PCP and discuss whether or not the medication needs to be changed. The member was not present so this would not be billed by the PCP, but could be billed as a Health Home service (care management).

If a Health Homes member is on a spend down and he meets the spend down amount on the 14th of the month, can he then be provided Health Homes services on the 15th and can we bill for that?
Yes. When the member meets his or her spend down amount, s/he becomes eligible for Medicaid and can receive Health Homes services.

How would a provider monitor an individual's spend down status?
The Lead Entity (MCO) and the Kansas Medical Assistance program (KMAP) website are the tools a provider uses to monitor a KanCare member's spend down status. The KMAP website is: https://www.kmap-state-ks.us/.

How quickly will the Lead Entity notify the HHP of a client that is on a spend down?
The HHP will need to check the KMAP website (https://www.kmap-state-ks.us/) to determine whether the member has met their spend down.

Tell us as much as you can about the reimbursement arrangements for Health Homes.
For detailed information about how the rates were developed and how each level is determined, please refer to the Payment Methodology sections in the program manuals found here:
http://www.kancare.ks.gov/health_home/providers_materials.htm

They are going to negotiate the PMPM between MCO & HHP on each consumer?
It would be impractical for the MCOs to negotiate payment for each HH enrollee. Generally, the MCO will negotiate payment per each HH Partner, based on a variety of factors, including how many of the six core services the HH Partner will be performing.

Describe in greater detail the latitude the State will allow the MCOs in payment plans for HH.
The payment rates between Health Homes Partners and the KanCare MCOs are direct negotiations that will take place between those two entities. The State will review and approve any non-PMPM payment arrangements between the MCO and

Health Homes Partner. The payment structure between the MCO and the Health Homes Partner will be a sub-capitated payment structure and will be reviewed by the State for reasonableness.

Is the shared payment to HH just a sub capitation of the rates the MCO gets?
Yes.

What payment methodology will be used by MCOs in reimbursing Health Homes for their services? (i.e.: Will various care management or coordination of services be reimbursed at differing rates and on a fee for service basis?)
A sub-capitated payment structure will be used by the MCOs to pay the Health Homes Partners.

Have reimbursement rates, including per-member/per-month, SMI, & Chronic, been determined for Health Homes?
Yes. See rate tables below:

SMI Health Homes PMPM Rates, Effective July 1, 2014:

Level	Rate
Level 1	$117.21
Level 2	$153.51
Level 3	$185.17
Level 4	$327.48
Average	$171.79

Chronic Conditions (CC) Health Homes PMPM Rates, Effective July 1, 2014:

Level	Rate
Level 1	$108.31
Level 2	$142.61
Level 3	$208.46
Level 4	$421.25
Average	$147.89

Why are the MCOs getting the PMPM when providers can likely manage the population better?
The State has determined that the PMPM will be paid to the MCO because they are already managing all the services provided to KanCare members and pay for those services so they have all the data for all services provided. We also want a broad range of HH Partners and the MCOs have the capability to support a variety of providers to serve as HH Partners.

Since rates are currently established for many behavioral services (i.e.: CPST, psychosocial, peer support) Will these change?
No.

Do all Lead Entities have the same payment structure to HHPs? What are they?
No, each will develop payment structures depending upon what each Health Homes Partner agrees to do.

Will payment to providers be equal between MCOs?
No. The State will not direct all payments to be equal. The payment rates between Health Homes Partners and the KanCare MCOs are direct negotiations that will take place between those two entities.

-Will the HHP know the PMPM paid to the MCO when contracting for a rate to the HHP?
-Will the HH be aware of the PMPM rate the MCO receives?
-Yes. The rates will be published on the Health Homes website. State HH payments to the MCOs will be structured to be adequate in ensuring quality HH services are sustainable.
-Yes. CMS requires that we publish/post the Health Homes rate methodology.

Will HH be aware of the PMPM rate the MCO receives?
Yes. Once the State Plan Amendment is approved by CMS, the rates will be published on the Health Homes website.

Will MCOs be able to withhold payments to Health Homes Partners based on outcomes?
No. However, the State will review and approve any non-PMPM payment arrangements between the MCO and Health Homes Partner.

Will there be a required amount or % the MCOs will be required to pass on to HHP?
No. The payment rates between Health Homes Partners and the KanCare MCOs are direct negotiations that will take place between those two entities. The State will review and approve any non-PMPM payment arrangements between the MCO and Health Homes Partner. The State will also review the sub-capitated payment to the HHP for reasonableness.

If the HHP receives PMPM only if one or more core services is/are provided in a given month, will the MCO still receive the PMPM?
The State will pay each MCO a PMPM payment for each member enrolled in a health home. Tiered systems of capitated payments based on service delivery are currently being considered as the State develops the final payment methodology.

This may consist of a base capitation rate for enrolled members, and a higher capitation rate for service delivery in a given month or quarter. The final payment methodology between the State and the MCO is currently being developed, and has yet to be submitted to CMS for approval.
The State will review all payment agreements between the MCOs and the HHPs. Also, the State will review and approve any non-PMPM payment arrangements between the MCO and Health Home Partner.

Does Lead Entity get the Per Member/Per Month (PMPM) payment if the HHP doesn't provide a service during the month?
No, unless the Lead Entity provides a service directly to the member. Payments will be issued by the State to the Lead Entity (MCO) once a service has been utilized. If no service has been delivered to a Health Homes member, no payment will be issued to the Lead Entity.

Will PMPM differ according to Medicaid category of consumer?
The State's actuaries are still developing the PMPM rates for the first Health Homes population, SMI. It is likely the SMI PMPM rate will differ from the rate developed for subsequent Health Home populations.

Is there any consideration to basing PMPM as a payment regardless of how many core services are provided, and have HHP receive incentives based upon outcomes? So, base PMPM for being the HHP, then receiving the PHP based upon patient outcomes? (If you are interested, the State of Maine has done this for years for their PCCM program.)
The State is considering these alternative payment methodologies.

What incentive does the HH have to improve the individual outcomes? (Shared risk)
Any non-PMPM payment arrangements between the MCO and the HHP will be reviewed and approved by the State.

Is there going to be incentive for consumers who opt (in) to be part of Health Homes and as a result their health costs went down? (Consumers need to be encouraged to reduce costs)
The approach Kansas is talking to HHs is not an "opt in" approach, but rather a passive enrollment, "opt out" approach. So the person would be assigned to a HH and then have to opt out if he or she did not want to participate. The MCOs are well-placed to offer incentives to HH enrollees and already do so in the KanCare program.

Will the State consider a risk adjustment methodology for MCO/HH based on an aggregate activity of each MCOs population?
The State is developing the payment methodology under which the PMPM will be

paid by the State to the MCOs. Regional cost factors, risk adjustment factors and a tiered payment structure are some examples of the payment methodology options currently being considered by the State.

Can the HH payment subgroup commit to delivery of a list of reimbursement variables that will not be addressed by the subgroup for 1/1/14 by 11/15/13? (e.g. one that we know is that the State will not approve PMPM arrangements between MCO & HH Partners. Are there other items like this?)
Yes, this is possible.

Will Health Homes payments arrive separately from other KanCare payments?
No, Health Homes payments will be remitted via our standard process.

Will there be funding for reimbursement for travel to and from appointments?
The Health Homes rates are a Per Member/Per Month (PMPM) bundled rate for delivering one or more of the six core Health Homes Services. If travel to and from appointments is part of delivering one or more of the six core Health Homes services, it could be a component of eligible billing to the Lead Entity (MCO). This will be negotiated in the contract and payment between the Health Homes Partner and the Lead Entity (MCO). Transportation services provided to KanCare members for medical appointments will not change if the member is in a Health Homes.

How is the cost of signing on with the Electronic Health Record covered? Can it be negotiated in the reimbursement rate?
The non-medical loading component of the Health Homes rates includes Information Technology costs associated with Electronic Health Records. Some providers may be eligible for meaningful use funding. More information about meaningful use funding can be found on KDHE's meaningful use website: http://www.kdheks.gov/epi/meaningful_use.htm. Additional resources regarding Health Information Technology for Health Homes can be found on KDHE's Health Homes website: http://www.kancare.ks.gov/health_home/providers_materials.htm.

How are RN's already employed by CSP's going to get utilized and reimbursed?
If the Community Service Provider is a HHP then the RN can be a care coordinator and the HHP would be reimbursed through regular Health Homes services. If the CSP is not a HHP the RN would be paid for as s/he already is.

Will the Administrative costs that are built into the rate structures be the amount the Lead Entity will keep?
Each Lead Entity's Health Homes program and payment structure is unique. A

Health Homes Partner's Per Member/Per Month (PMPM) payment from the Lead Entity will be dependent upon many factors, including but not limited to how many of the six core services the Health Homes Partner will deliver, or subcontract to deliver.

What services would fall outside of the Health Homes and be reimbursed separately by the MCO?
Any physical or behavioral health service the person already can receive under KanCare, including physician, hospital and pharmacy services, mental health or substance use disorder services or home and community based services already covered in KanCare. If the person also receives home and community based waiver services, those also will continue to be reimbursed separately.

Do you have to be an established company before you can contract as a HHP or can you be a brand new provider?
You must meet the requirements outlined in the documents found here: http://www.kancare.ks.gov/health_home/providers_materials.htm.

Is there a contracting template available?
Once the Lead Entities/MCOs share those with the State, they will be shared with the various provider associations for their feedback.

Are Health Homes Partners responsible for finding Partners to subcontract with?
You should be working on that now in your community, but the Lead Entities/MCOs can also help you learn who is willing to subcontract in your area.

What if all of the organizations in a service area only express an interest in subcontracting and no one is interested in leading the effort?
The Lead Entities are responsible for making sure Health Homes are available Statewide. They will work with providers to ensure that some can be HHPs.

Do you have to be enrolled in KanCare as a provider to be a subcontractor?
Not necessarily. It depends upon what service you want to sub-contract for and whether the HHP requires it.

As a subcontractor, would an agency contract with Health Homes Partners or with Lead Entities?
You would contract with the HHP.

Which of the core services would be most appropriate for a type of provider to subcontract?
Comprehensive care management and care coordination are the two least likely to

be subcontracted since they are core to Health Homes. Health promotion and referral to community and social supports services are probably the two services that lend themselves most readily to subcontracting.

If you're a Health Homes Partner, can you also subcontract for other HHPs who don't provide your services for their consumers who did not choose your health home?
Yes.

How does subcontracting work for a Local Health Department where we already work under a physician? Does the physician need to start the process first?
That is going to depend upon who has authority for your LHD to enter into contracts.

Will a Business Associate Agreement with an agency cover the Affordable Care Act HIPAA requirements? (subcontractors, other providers, etc.)
Yes.

Under what circumstances does "Partnering" involve the exchange of money vs. the "service" being an already existing natural or established resource?
Certainly, if you can access some services that already occur in your community, without having to subcontract and pay for them, that is great. An example might be just offering space at your facility for a chronic disease self-management (CDSM) class that is open to the public and you can send some of your consumers to it.

What entity(s) has responsibility for State psychiatric hospital admission, treatment, discharge and payment?
CMHCs will still perform the screenings for admission to State psychiatric hospitals. HH members who must be admitted to these hospitals will still be eligible for HH services in order to ensure comprehensive transitional care – one of the six core HH services. Payment for State psychiatric hospital stays will not change under HHs.

<u>Health Action Plan (HAP)</u>

What is the protocol for setting up a HAP?
The HAP is developed following a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs. The HAP is developed with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), Health Homes Partner (HHP), member, family/support persons, guardian, and health services and social service staff.

Are all service providers participating in developing the HAP?
Ideally, all entities that will be involved with the implementation of the member's HAP should participate, either by participating during the actual development of the HAP, or at least weighing in on what might be included.

Will training be available to providers on how to develop a quality HAP?
Offering training may be possible if providers are having problems developing HAPs.

Does the Health Action Plan have to be a separate document from the SMI clients' state-required treatment plan? Can it be consolidated?
It is a separate document that will incorporate information from the treatment plan.

It was noted that HAPs require physician oversight, what is an example of what is expected?
While a physician may be a part of the member's Health Homes team, and may provide services that contribute to a member's goals, the physician does not have "oversight" of the HAP. The HAP is a tool to document the member's:

- Health Homes goals.
- strategies to achieve goals.
- progress towards achieving goals.
- member and providers specific responsibilities related to Health Home goals.

It is the responsibility of the Partner providing Comprehensive Care Management to ensure that a HAP is developed, and the responsibility of the Partner providing Care Coordination to assist the member to implement the strategies listed on the HAP, as well as document progress toward meeting goals.

Health Information Technology (HIT)

How do you define "interoperable" Electronic Health Record (EHR)?
Please refer to this link for an easily understandable definition of interoperability and how that fits with Health Information Exchanges (HIEs): http://www.healthit.gov/buzz-blog/meaningful-use/interoperability-health-information-exchange-setting-record-straight/.

Is it a process and quality outcomes database?
An EHR is not just a database. It is a patient record which allows staff to enter and retrieve relevant health information, as well as to share it with other, appropriate Partners and Health Information Exchange.

What does it take to connect to Health Information Exchange (HIE), Kansas Health Information Network (KHIN) & Lewis and Clark Information Exchange (LACIE)?
Please contact either or both of these exchanges for the answer to this question: http://www.khinonline.org/ and/or http://www.lacie-hie.com/ .

Does an EHR have to connect directly to KHIN or LACIE to be accepted/approved?
Not initially, but you should have a plan to connect.

Will the Lead Entities prefer HHPs to use the EHRs they already have in place?
If your agency already has an interoperable EHR, you already meet the requirement, but you will still need a plan to connect to one of the certified HIEs, KHIN or LACIE.

Do you have to have an EHR if you are subcontracting?
That is going to depend upon what you're sub-contracting for, but in most cases, you may not need one.

What EHR can link to provide Points of Contact (POC)?
For an answer to this , we suggest you ask your POC vendor.

If a guardian "opts out" on the use of Information Technology, is there somewhere to require electronic Information Exchange participation by the client?
No.

Does the State have plans for disease registry and prescription possession ratio system?
The State will not maintain any health information databases. We expect MCOs and HHPs to use their existing tools, as well as the State health information exchanges (KHIN and LACIE) to share information.

Everyone recognizes that the barriers to effective and efficient EHR are systems that don't connect and talk to each other. Why are we seeing 3 MCO systems being developed that apparently don't talk to each other?
The State expects MCOs and HH Partners to use the existing health information exchanges to share information. Each MCO has its own care management/coordination software, but the State expects MCOs and HH Partners to use the state health information exchange. Each MCO has developed proprietary software to be used internally, but they are all required, contractually, to be able to link to the two certified health information exchanges (KHIN and LACIE) and to help their contracted providers to also do so.

How does the HIT requirement for Health Homes (and KanCare for that matter) tie into the State's current effort for Health Information Exchange? (The efforts are the same and shouldn't be in isolation from each other and

shouldn't create a new & different data systems). Will MCOs be able to implement a shared access system for Health Homes Partners so all partners have access to patient data (with patient consent)?What type of IT software will be needed to "link" or "interface" with other service professionals within the Health Homes?

Kansas has two certified State health information exchanges, the Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE). The state expects MCOs and HH Partners to work toward using these exchanges to share information across providers. HH Partners should have or be in the process of developing/acquiring an electronic medical record that will be able to interface with either of these exchanges. Use of either of the two certified health information exchanges, the Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE), allow for this exchange of information.

Will all Health Homes Providers be required to have Health Information Technology? Be able to access or provide records electronically?

Yes.

For all MCOs: Will HH Providers be able to run any reports for care gaps & alerts within the clinical portals for all patients for whom we are HH or is it individual patient query only?

Amerigroup: Will initiate this by including all of the Health Homes Providers in the distribution of various reports that indicate a gap in care needs (KAN Be Healthy exams, immunizations, HEDIS-type measures, etc.)

Sunflower: All Primary Care Providers (PDCP's) and designated Health Homes Providers with authorized portal access are able to view, print, or export to Microsoft Excel a list of all Sunflower Members in their care, and they are able to filter Member data to list only those Members with care gaps/alerts. We are currently expanding this reporting functionality to include the ability to filter the Provider panel to report Members with special healthcare needs, including chronic conditions and disease states; for example: Heart Disease, Developmental Delay, Physical Disability, or if our Member has a visual or speech impairment. All other authorized providers are able to view care gap information when they search for a specific Member through our Member eligibility search function. This functionality supports our providers in their effort to outreach to Members and assist those Members in the event of a crisis situation. United: It is our expectation that the providers (Health Homes Partners) will be able to access their members by individual query, but are hoping to provide a group identifier which would allow a filter for the HH members.

Sunflower Plan-Who has access to the member health record? Only patient/members?

All providers with authorized access to our Sunflower clinical portal are able to view the Member health record, which includes: care gaps and alerts, visit history with primary diagnosis, medications, lab information, immunizations and allergies, when we have this information. Providers are also able to view any completed health assessments, and Care Plans used by our care managers.
Members are able to view their care gaps and alerts, as well as their visit history through the on-line claim functionality. Additionally, we are in the process of making available specific Care Plans for Members available on our Member Portal, for those Members in case management who have specific conditions, such as diabetes. Care Plans for our Members are presented in language that is easy to understand, with defined, measurable goals. We also provide our Members with the ability to create and maintain their own electronic Personal Health Record (PHR) using the Microsoft HealthVault service. For Members who create a HealthVault account and notify us of this, we have their claims and pharmacy claims data securely sent to their Microsoft HealthVault account - for viewing and use by the Member or anyone to whom the Member delegates viewing authority.

Will MCOs require the provider to enter clinical twice-once for their HIT systems & our EMRs?

Amerigroup: Proposes that providers bill the CPT or HCPCS code designated by the State to indicate a Health Homes Provider encounter and then document in the patient record (according to the documentation standards) rather than duplicate patient information in multiple places.

Sunflower: We do not ask our providers to enter clinical data twice; we enable information exchange with our providers leveraging the capability that they have available to them.
For all our providers who have internet, we offer access to our secure, web-based Provider Portal which allows providers to perform self-service, administrative transaction services online via the internet; such as check eligibility, submit authorization requests, submit batch HIPAA claims and/or supporting attachments and documentation, enter claims online, view explanations of payment (EOP), register for electronic payment (EFT), and a variety of other functions.
As it relates to other medical information, all authorized Providers are able to view our Member Health Record which organizes health information for our Members that we have available to us including: HIPAA compliant medical and behavioral claims, demographics, data, and lab results that we obtain via HL7 interface with our lab providers, completed assessments, care gap and alert information.
Additionally, for those providers who have their own Electronic Health Record, these providers will be able to print the MHR as a PDF and/or securely export the MHR from our portal in Continuity of Care Record (CCR) or Continuity of Care Document (CCD) format (if the provider has a standards-based EMR or viewer to use the CCR or CCD data).

United: At the present time, our Community Care Manager is a stand-alone application.

The MCOs appear to all have their own proprietary software for managing and reporting Health Homes HI. Will provider partners simply log on and document services for no charge? Will providers need to purchase any software to manage care?

Amerigroup: Proposes that providers bill the CPT or HCPCS code designated by the State to indicate a Health Homes Provider encounter an then document in the patient record (according to the documentation standards) rather than duplicate patient information in multiple places.

Sunflower: As mentioned above, all providers with internet access who are registered users of our Provider Portal are able to perform self-service, administrative transaction services online, submit authorization requests, submit batch HIPAA claims and/or supporting attachments and documentation, etc. Providers do not enter clinical notes into our Member Health Record, rather we display information to our providers based on medical and behavioral health claims, and other data we have available, such as pharmacy and lab data, completed assessments, and care gaps and alerts based on reports from our Centelligence™ Foresight suite of predictive modeling tools.
We will be making available to our network of PCPs a growing number of reports at no charge. For example, the following reports are or will be available on-line in 2014: high cost Members, PCP pharmacy detail by patient, pharmacy summary by Member by PCP, Emergency Room (ER) frequency, ER Early Alerts, ER Visit Follow-Up, Non-emergent ER, Members not Seen by PCP, etc. Providers do not need to purchase software to view these reports; they will be available in pdf format.

United: United's Community Care Manager is proprietary. The MCO's are currently having discussions on documentation processes, and more information should be available as the HIT/HIE integration advances.

Is it required for Health Homes providers to have EMR? What is "demonstrate a capacity to use health information"? (i.e. KCPC for SED)
The State, and CMS, expects that HH Partners will develop capacity to have an electronic medical record that will be able to feed information into one of the two certified state health information exchanges (KHIN and LACIE).

Quality

Reporting Outcomes to Sate and MCOs-Will there be one standardized form for this? Otherwise we will be spending more time, energy & money on measuring and writing reports than on providing services to our clients. Will the State require that all MCOs use the same reporting information?

The processes for reporting quality measures will be standardized and the sources utilized to collect the data are defined in the 'Proposed Kansas Health Homes Quality Goals and Measures'. All three MCOs will report on the same defined measures with associated numerators and denominators.

Measurements of Outcome-What standardized measurements are being considered? Will all 3 MCOs require/utilize the same measurement instrument? (Would be more manageable and efficient)
The standard measurements under consideration are included in the document titled 'Proposed Kansas Health Homes Quality Goals and Measures', found here: http://www.kancare.ks.gov/download/HH_Forum_Document_Goals_and_Measures.pdf. The first five pages contain the draft State Quality Goals and Measures and pages 6 and 7 include the CMS Core Quality measures.

Data and Documentation

Will there be a universal data collection tool created for use to meet all Lead Entity needs?
No.

How does an organization know what data will be expected to be completed for each individual monthly?
There is a documentation requirements table in the Program Manual (found here: http://www.kancare.ks.gov/health_home/providers_materials.htm) that lays out what the Lead Entities expect in the way of documentation for each Health Homes service.

When will the State/MCO's make the transition to DSM-5 and ICD10 to capture the correct diagnosis for SMI?
A crosswalk to the DSM-5 for the SMI diagnosis can be found here: http://www.kancare.ks.gov/health_home/providers_materials.htm. We plan to transition to ICD-10 prior to the CMS deadline.

What if a provider within the service team refuses to collect and/or share information related to the tracking measures for the HAP (i.e.: Health Care Provider, Child Welfare Community Based Service Provider, etc.)?
Assuming these providers all contract with the Lead Entity/MCO for those services,

you can enlist the Lead Entity's help, but we hope Health Homes Partners will approach all providers in a spirit of collaboration and by helping everyone understand the importance of sharing information to best coordinate care and determine outcomes.

Consumer Issues

What is the penalty to the member for ongoing noncompliance?
There are none. Participation in Health Homes is voluntary. We expect the Health Home to work with the consumer to help them understand the need for cooperation. It may be that Health Action Plan goals need to be very small at first to encourage cooperation and allow the member to see progress.

Is there a penalty to the member if they "opt out"?
No.

If a member opts in for a Health Homes and goes to a non-Health Home Partner, will the member be responsible for charges (i.e.: penalty)? Is this a similar structure to a lock-in provider?
No. Health Homes are not lock-in providers, which are used when a member is abusing medications. Remember that the six Health Homes services are **in addition** to any other KanCare services the person receives. A member cannot receive Health Homes services from anyone but the Health Homes Partner, Lead Entity or a subcontractor of the HHP, unless the member asks to switch to a new HHP.

Is there a minimal amount of contact that the individual must have in order to continue to qualify for a Health Homes?
The member must receive at least one of the six core health Homes services in a month in order for the State to pay the Lead Entity/MCO and for the Lead Entity to pay the Health Home Partner.

What if the provider is unable to make contact with a member to provide a service (comprehensive assessment, HAP, etc.) after several attempts to do so?
That should be documented and the HHP should enlist the aid of the Lead Entity to help engage the member. We expect the HHP to go beyond phone calls in their attempts to contact the member.

Managed Care Organization Processes

Will there be "a" Health Homes model or will each MCO have a different model?
There is a single model, as defined by the State and outlined in the Health Homes 101 presentation. MCOs may have different agreements with different HHPs, based on the HHP's ability to deliver the core HH services.

Will the service division be similar between MCOs?
Not necessarily. The State wants Health Homes to be developed in as flexible a manner as possible to ensure they can meet the unique and varied needs of the population who will be served by them. In addition, not all potential HH Partners have the same capabilities.

When will the Lead Entities contact potential HHPs regarding their submission of the PPT?
The MCOs shall respond to potential HHPs within 10 days of receiving the completed Tools. Within 45 days of receiving completed Tools, the MCOs will have a follow-up discussion (either in-person or over the phone) with potential HHPs regarding their readiness to serve as HHP. After the follow-up discussion, the MCOs will have 10 days to provide potential HHPs with a contract amendment and the potential HHPs will have another 10 days after receiving the contract amendment to sign and return the contract amendment to the MCO.

If you intend to work with all three Lead Entities, would there be an in-person or over the phone follow-up discussion with all three Lead Entities?
Please see answer above. Each MCO will contact you separately.

Is it possible to have the same HHP working with all three MCOs?
Yes. We hope HHPs will contract with all three MCOs to provide members with a choice of HHPs no matter which MCO the member is associated with.

With working with all 3 MCOs, will there be standard forms across the board? (ex. All the same form when addressing the Health Action Plan. Same assessment piece.)
The state has directed the three MCOs to work together to ensure that forms and processes related to Health Homes be as consistent as possible. We are also open to suggestions from providers as to how to help with that.

Can a Health Homes service provider sub-contract with the MCO and a Health Homes Partner?
Yes.

Will the MCOs be "allowed" to exclusively offer any of the 6 core services?
No.

Are the MCOs currently considering HHPs other than CMHCs for the initial SPA? Particularly to meet the special/unique needs of those members with dual diagnoses or co-occurring diagnoses?
Yes, and the State is encouraging a wide variety of HH Partners.

Are Lead Entities wanting to retrain specific core services, or intending to contract for all/almost all core services?

This varies among the Lead Entities. Please refer to their presentations contained in the PowerPoint from the regional provider meetings, found here: http://www.kancare.ks.gov/health_home/provider_regional_meetings.htm.

Will we be able to receive a copy of the PowerPoint presentation?
The presentation can be retrieved here: http://www.kancare.ks.gov/health_home.htm.

How will the Lead Entities fill in service gaps?
They must provide the missing Health Homes service directly, if they cannot find a HHP (with or without a subcontractor) who can provide the service in a specific area.

How does Comprehensive Care Coordination and Care Management interface with the MCO Care Coordinator? Are they the same?
They are not the same. MCO Care Coordinators primarily work telephonically with some limited face-to-face interaction. The MCO Service Coordinator will continue to perform the same level of service for our members as they currently do. The intent of the Health Homes program is for local providers to engage in face-to-face interactions with the member to help them manage their health. The MCOs may elect to maintain and continue to the work of their Care Coordinators. We expect the Health Homes Partner to collaborate with the MCO Care Coordinator in the coordination activities performed by the Health Homes Partner since they are considered part of the care team.

Please define your expectation for "comprehensive care management" (it appears from the diagram that this falls under the MCO responsibility). As the description provided by the MCOs in their published material, this is very encompassing, however, in my experience thus far, I have seen this function only as "pre-authorizations" but not the care management that encompasses the social determinants of health that so many of these beneficiaries lack.
The diagram you're referring to in the PowerPoint presentation is only for illustration purposes. There is not an expectation that the MCO will always provide comprehensive care management; the HHP may do so. Health Homes are expected to be intense and very focused care coordination. Comprehensive care management includes a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs, and the development of a Health Action Plan (HAP) with input from the member, family members or other persons who provide support, guardians, and service providers. The HAP clarifies roles and responsibilities of the Lead Entity (LE), Health Homes Partner (HHP), member, family/support persons/guardian, and health services and social service staff.

Critical components of comprehensive care management include:

- Knowledge of the medical and non-medical service delivery system within and outside of the member's area.
- Effective cultural, linguistic, and disability appropriate communication with the member, family members/support persons, guardians, and service providers.
- Ability to address other barriers to success, such as low income, housing, transportation, academic and functional achievement, social supports, understanding of health conditions, etc.
- Monitoring and follow-up to ensure that needed care and services are offered and accessed.
- Routine and periodic reassessment and revision of the HAP to reflect current needs, service effectiveness in improving or maintain health status, and other circumstances.

What is the expectation from the HHP for "care coordination" and what is reasonable reimbursement in your opinion to help fund this service?

Care coordination with in the HH in the first SPA is defined as:

Implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and supports. A dedicated Care Coordinator is responsible for overall management of the member's HAP, including referring, scheduling appointments, following-up, sharing information with all involved parties including the member, monitoring Emergency Department (ED) and in-patient admissions to ensure coordinated care transitions, communicating with all parties during transitions of care/hospital discharge, referring for LTSS, locating non-Medicaid resources including natural and other supports, monitoring a member's progress towards achievement of goals, and revising the HAP as necessary to reflect the member's needs. Care coordination:

- Is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals.
- Supports adherence to treatment recommendations, engages members in chronic condition self-care, and encourages continued participation in HH care.
- Involves coordination and collaboration with other providers to monitor the member's conditions, health status, and medications and side effects.
- Engages members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of-life decisions and supports.
- Implements and manages the HAP through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact.
- Creates and promotes linkages to other agencies, services, and supports.

The MCO will pay a portion of that PMPM to the HHP, as a PMPM for the bundle of HH services the HHP provides.

Please explain the difference between Care Management and Care Coordination.
Care Management is about getting the member in the HH and engaged, as well developing the Health Action Plan. Care coordination is the implementation and ongoing monitoring of the plan. For more detailed information, please refer to the two responses immediately above.

Will all Lead Entities have regional staff?
The Lead Entities will have staff located in certain areas of the state to support providers on an ongoing basis based upon member enrollment and Health Homes Partner network development. Location, area of responsibility, and scope of work are still to be determined, but this support would be available to all Health Homes Partners.

Who is assessing to assure Lead Entity staff met Health Homes qualifications?
The State. We will actually be conducting readiness reviews of the Lead Entities May 20-22, 2014.

Are the Lead Entities also concerned about subcontractors and their qualifications?
Health Homes Partners that subcontract any service must assure that the subcontractor meets the applicable requirements for the services performed and that the subcontract is compliant with KDHE subcontractor agreement requirements. Health Homes Partners must work to ensure that quality services will be delivered. This may also be a focus of the ongoing monitoring undertaken by the Lead Entities.

How will lead Entities audit providers to ensure they are doing what they are supposed to?
Just as the State audits Lead Entities, by reviewing a random sample of files.

If a person moves from one Lead Entity to another, will information/records flow from one to the other?
Yes, much like any other transition of a member from one MCO to another MCO, there is a process established for sharing any relevant member information. This requirement to share information is outlined in the State's Health Homes Program Manuals.

Will the "opt out" call-in number go to a person or a voicemail?
The number is the State's enrollment broker, HP, and is answered by live people.

<u>Targeted Case Management (TCM) for Individuals with Intellectual/Developmental Disabilities (I/DD)</u>

Is TCM available to a person in a Health Homes?
Not as a TCM. CMS has told us that they will not pay for TCM and Health Homes services for the same person, so we have established this requirement for Health Homes members who are I/DD: Every Health Homes must include the targeted case management (TCM) provider for any Health Homes member who has an intellectual or developmental disability (I/DD). The Lead Entity or the HHP must contract with the TCM provider if the I/DD member wishes to continue the relationship with that provider. The TCM provider will be responsible for various components of the sic core Health Homes services and these will be determined at the time the Health Action Plan is developed.

Will individuals be able to receive Targeted Case Management if they are in a HH?
No. The Centers for Medicare and Medicaid Services (CMS) have stated that Targeted Case Management (TCM) and certain HH services are duplication, so a member who is eligible for HH services will need to choose to be in a HH or to receive TCM. The State has determined that, for people with intellectual or developmental or developmental disabilities (I/DD) who are also eligible for HHs, the HH must contract with the person's TCM provider to provide some HH service in lieu of TCM if the person chooses to be in the HH.

Has the role of the TCM for I/DD members been clarified?
Yes. See the response immediately above.

What about Case Management? Will participants in Health Homes model be able to keep their current case manager?
Please see the response above.

Many individuals with I/DD already have residential services and their medical needs are closely monitored by these agencies so, how will a Health Homes improve/benefit/affect the quality of services for individuals with I/DD?
People with intellectual or developmental disabilities (I/DD) that are in a Health Homes will continue to receive all KanCare services they already receive, with the exception of Targeted Case Management (TCM). The treatment of TCM in Health Homes is outlined above.

How will TCMs in CSPs and independent case management agencies be affected by the Health Homes model?
HHs will be required to contract with any agency or individual that provides TCM to a person with I/DD who chooses to remain in a HH. That agency or person can also continue to provide TCM to other people with I/DD who are not in HHs.

If someone opts out of Health Homes will similar services be available to them, i.e. TCM?
People with I/DD will still have TCM available to them if they opt out of HHs.

This service appears to be like direct care if the individual doesn't want to cooperate and go to needed medical appts. And the TCM may have to accompany the person. Is this allowed, or do I not understand the rationale of the TCM's involvement?
Health Homes are not direct care, in the sense of direct in-home or residential support. Six core services are provided to the member and are described in detail in documents found here: http://www.kancare.ks.gov/health_home/providers_materials.htm. Care coordination in Health Homes is more direct and intense than for regular KanCare members. In addition, health promotion seeks to engage the member more directly in the management of his or her own chronic conditions. Target Case Management cannot be provided to people in Health Homes; however, for HHPs, must include the Target Case Management (TCM) provider as part of the Health Homes team for any member who has an intellectual or developmental disability (I/DD). The TCM provider will be responsible for various components of the six Health Homes services and these will be determined at the time of the Health Action Plan is developed.

If a TCM provider chooses to not become a HHP will we lose the clients that want to be in the Health Homes program?
No. As long as you are willing to subcontract with HHPs to provide TCM-like services to members who are in Health Homes, you will receive a guaranteed monthly payment for those members of no less than $137.32 for I/DD Health Home members in the SMI Health Homes and no less than $208.75 for I/DD members in the CC Health Homes.

Does this affect services to individuals with I/DD who are not eligible for Health Homes?
No.

How do foster care homes serving children on the I/DD waiver fit into the Health Homes delivery system?
If these children are eligible for Health Home services they will be subject to the I/DD TCM guarantees noted in the answers to the 2 questions above. The state child welfare contractors responsible for the placement of the children would be responsible for the choice of HHPs for these children.

Does this affect services to individuals with I/DD who are not eligible for health Homes?
No.

Will the TCM agency be notified of who is included in the Health Homes? How?"

If the TCM agency is a HHP, they will be notified if members are assigned to their Health Home. Members they serve will receive the Health Homes assignment letter. If TCM agencies are not the Health Homes Partner, we expect that the Health Home Partner will reach out to the TCM agency to determine if they are interested in participating. The TCM will need to have a process for coordinating with the consumers they serve to determine which of their consumers have been assigned to a Health Home so they can assist the consumer in accessing/contacting/working with the Health Homes Partner.

Does the Health Homes program require the Targeted Case Manager to perform non-TCM type duties?

Health Homes services allow more flexibility than does TCM, so the Targeted Case Manager may be able to do some things they couldn't do and be reimbursed for under TCM. Generally, the tasks will be the same things a case manager would do under TCM.

What happens if the individual wants to keep their TCM services buy change to another TCM provider?

They can do that and the new TCM provider would receive the guaranteed payment.

Provider Roles & Core Services

How do the different entities such as rural clinics, health departments, and pharmacies fit into the Health Homes picture?

Any provider who is serving someone in the Health Home will be involved in that member's care. The Health Homes will coordinate all the providers. Rural Health Clinics and Local Health Departments could also become HHPs if they meet all the requirements. Almost any type of provider could also subcontract with the HHP to provide one or more Health Homes service.

Will pharmacies have a role in this?

Absolutely. HH members will still receive pharmacy services from their established providers. Health Homes services are provided in addition to all the other services a member receives under KanCare.

Is there a contract a pharmacy has to sign for this and information available on what our role is? Will the members be locked into that pharmacy provider?

No. If you are already contracted for KanCare, you will continue to provide pharmacy services per usual to HH members. HH members will not be "locked into" certain pharmacies. People who are in HHs will continue to have the same relationships they already have with their physical and behavioral health care and long term supports and services providers.

How will we deal with consumers with providers not connected with a particular MCO?
To serve as a HHP, the provider must contract with an MCO. If there are individual service providers working with a HH enrollee, the MCO and HHP will need to try to coordinate all service, even those outside the MCO network.

Who is going to "market" the Health Homes program to Doctors, hospitals, etc.?
We have had representatives from the Kansas Medical Society and the Kansas Hospital Association on our stakeholder group for well over a year. We have also sent out information through those associations. We will continue to engage and educate all provider groups as we move into implementation and beyond.

Will Health Promotion activities have to be provided by a licensed health professional?
No.

Will a HHP need to subcontract 24 hour emergency access care or would our staff be on call?
The requirement you're referring to is a joint Lead Entity/HHP requirement and can be met with the Lead Entity's 24-hour nurse line. There are a number of other ways to meet the requirement without having staff on call. The requirement is for availability of information and emergency consultation services to enrollees.

How will peer support be implemented or used within this model?
Peer Support professionals are a required part of the SMI Health Homes team and are associated with several services. Please refer to the draft SMI Health Homes State Plan Amendment and the SMI Health Home Program Manual, both located here: http://www.kancare.ks.gov/health_home/providers_materials.htm.

Now, patients are all doing what they want and the PCP has no control of it. Why do you think your model will work?
Patient engagement is a key component of Health Homes. Inclusion of providers with whom the member already has a relationship with will help with that. The MCO and the HHP will work together to get, and keep, the member engaged. One of the six core HH services is health promotion which is designed to engage the member in talking an active role in helping to manage his or her chronic conditions. The Kansas HH model also includes Peer Support as a way to help with this.

The Care Coordination services provided in Health Homes are typically thought to be face to face (nationally). Does KanCare agree?
Generally, yes; however, there may be legitimate reasons to include telephonic and other types of contacts in the course of delivering care coordination services.

Does the enrolled individual have any input on who their "dedicated care manager" is?
Yes. HH enrollees will have a choice of Health Homes, including the MCO and the HHP.

Will the existing MCO service coordinators or case managers be providing the care coordination?
Depending upon the HHP, the MCO could be providing care coordination or it could be done by the HHP. The agreement between the MCO and the HHP will spell that out.

What Home Health Core Services do the MCOs envision themselves providing and which ones do they believe they will contract with a Health Home Partner?
There are no services reserved exclusively for the MCOs. HH Partners who contract with the MCOs and demonstrate that they can provide all six core services could do so, if both parties agree to that.

In the Health Homes model, what is the roll of Cenpatico and Optum in delivering the six core services in Partnership with HHPs-particularly since the first population is SMI?
As MCO subcontractors for behavioral health services they will support HH Partners in the delivery of HH services.

Do MCOs see possibility of contracting with CMHC outside of client's catchment area for service delivery? (i.e. what if local CMHC doesn't offer co-located physical healthcare services, but another CMHC does?)
CMS requires that HH enrollees have choice of HH providers. We interpret that to mean both a choice of MCO and a choice of HH Partner.

<u>Misc.-unsorted</u>
Do you plan to have any specific required assessments in the Health Homes (i.e. WA requires PAM)?
We expect Health Homes to perform a complete biopychosocial assessment on the individual, as well as to use whatever other assessment data has been gathered by various providers and made available to the HH. The PAM is a tool to assess how involved the patient is becoming in his or her health care. It is certainly not going to be prohibited, but will not be mandated.

Is it the expectation for there to be one rehabilitation plan that would meet the test for both a CMS treatment plan & a person centered action plan?
Kansas will require a Health Action Plan that incorporates components from other state-required plans. Various service systems, e.g. mental health, I/DD, substance

use disorder treatment, all have specific plans they must produce for their licensing entities and HH Partners could come from any of these systems or others.

Will the Health Homes Care coordinator be the same care coordinator that people on HCBS waivers already have? Or will they have 2 care coordinators?
The provision of care coordination will be negotiated by the MCO and the HH Partner.

Can a HH decline to provide a service(s) to a person referred by a MCO?
One of the requirements for becoming a HH Partner is not refusing someone who is eligible and assigned to the HH Partner, except for very narrow reasons. Generally, HH enrollees will be assigned based upon their experience and relationship with available HH Partners in the MCO networks.

When will people with primary condition of substance dependence go into Health Homes?
Many people with SMI also have co-occurring substance use disorders. The HH is responsible for approaching the enrollee's health issues holistically, regardless of what type of provider the HH Partner is. Substance use disorders are also be analyzed as part of the research into the second target population for HHs, beginning in July 2014.

Will the Health Homes community provider have to provide transportation to appts (PCP & specialists)? Will we be expected to go in person to each apt or specific ones? If so, who will determine this?
No. NEMT is still available to HH enrollees as part of the KanCare program. There may be times when it would be helpful for someone from the HH to accompany the enrollee to a certain appointment. The Health Action Plan and individual circumstances will help determine that.

What would be an example of "other services" that would still be provided by a CMHC and billed to the MCO?
Any of the services currently listed in the Medicaid State Plan and covered under KanCare, such as Outpatient Therapy, Community Psychiatric Support and Treatment, Peer Support, etc.

One of the objectives of HHP is to provide community & social supports for members to enhance their well-being. How will you (MCO) provide incentives for the members to participate in their well-being? What will happen if the member refuses or is reluctant to participate in their well-being for the HHP?
MCOs already provide certain incentives for members to complete certain wellness and prevention activities, so they are well-placed to provide other incentives for HH

enrollees. Since Health Homes will be a State Plan service, CMS will likely not allow Health Homes to dis-enroll HH members who are non-compliant.

How will it be determined/decided what MCO will do & what HH Partner will do within the six core services?
This will be negotiated between the MCO and the HH Partner.

Will the State send a list of people eligible for HH to providers so they could help the enrollees understand what is going on?
Yes we will examine how we can do this near the time when potential HH members are notified.

When will the enrollment letter go out to enrollees?
There is no specific date, yet, but the letters will need to go out before January 1, 2014.

If you are a HHP, do you have to provide HH to both SMI and Chronic Diseases clients? Can you choose not to do SMI?
No, you do not since there will be two different SPAs for the two target populations. A HH Partner can choose to provide HH services either to the SMI population or those with other chronic conditions, or both.

When a FQHC & CMHC are co-located & a SPMI consumer is using services from both agencies- which agency is the Health Homes?
CMS requires that HH enrollees be provided a choice of HHs.

If member has both SMI & diabetes (after July 2014), what is the designated Health Homes ? CMHC vs. physical care agency?
The HH enrollee would have a choice of Health Homes.

How will the HHP or MCO know what each consumers needs are to begin with?
The MCOs already must complete a health risk assessment (HRA) on each KanCare member, so they will have that information to begin with. In addition, a complete biopsychosocial assessment will be completed to help develop the Health Action Plan (HAP).

Having 3 contracts (one w/each MCO) for CMHC will be confusing for consumers. How will the state address this confusion? Is this an issue for your consumer focus group?
Contracts and agreements between providers and MCOs should not be an issue for consumers, unless providers or MCOs make them aware of such agreements and contracts. There is no need to do so. Consumers will be informed of their opportunity to participate in a AHH and who the potential HH Partner is. In addition,

they will be provided information about how to opt out and how to choose a different HH partner should they wish to do so.

If a provider is already contracted with an MCO (Sunflower, Optum, Cenpatico) does this mean the provider is already contracted to be part of the Health Homes network? What does the provider need to do to become part of the system?

The MCOs have indicated that providers who already have contracts with for KanCare would likely only need an addendum to the contract to be a HH Partner; however, they must meet the HH Partner standards and qualifications and be able to provide one or more of the six core HH services. Providers interested in becoming HH Partners should contact the MCOs. In the meantime, you should talk with your designated provider representative to let them know you are interested.

What happens to patients going in & out of Medicaid once they are part of HH?

This will be a problem, but CMS does not allow states to exclude eligible enrollees from HHs. It will be important to ensure that members who lose eligibility are reattached to the same MCO and HH if the member re-attains eligibility within six months.

If we are currently providing case management, will it be paid as KanCare or Health Homes?

CMS has stated that people in Health Homes cannot receive Targeted Case Management as a separate service. They view these two services as duplicative. For someone in a HH, their case management would be part of the core HH services.

<u>Operations</u>

Are you going to post answers to the questions asked today on the website?

Yes.

Will the three MCOs use identical billing, monitoring, outcome measures and credentialing processes, tools, forms, etc.?

The three MCOs have been directed by the state to work together to develop consistent processes. Regarding credentialing, the MCOs have indicated that providers who already have contracts with them and who want to be HH Parners would need to sign an addendum to their existing contract.

How many Health Homes Partners do you project in Kansas?

We do not have a projection of numbers since we do not know how many of the 36,000 potential HH enrollees (of the first target population-SMI) will decide not to opt out.

Seems like patients would be more engaged in an "opt in" environment. Will we learn strategies to increase engagement? If patients don't cooperate & follow through (as many do know), are there consequences to the patient?
Experience in other states that chose the "opt in" approach indicates a very low take up rate for Health Homes. We want to get as many people as possible into HH and hope they will see the benefit as they receive the HH services.

Are there milestones for MCOs that need to be met such as 80% network providers in place by "X" date?
Not at this time.

Provider Qualifications

If they are looking at the costs of services and we know mental health costs are typically higher than substance abuse services, how will a SA provider ever get to be an option of HHP? Even if they could provide good services.
Any Medicaid provider who can meet the HH standards and qualifications and who can provide one or more of the six core HH services is a potential HH Partner.

If an adult care home (licensed) signs agreements to be a HH provider, will that guarantee they will be the HH Partner that coordinates necessary services?
No. CMS has some specific requirements related to nursing facilities serving as Health Homes and has stated:

> CMS will consider Health Homes proposals that propose to improve outcomes and change the trajectory of those Medicaid individuals in a nursing home with one or more chronic conditions such as mental illness/behavioral health conditions. CMS would also support Health Homes efforts to transition Medicaid individuals out of a nursing home, since that is a specific part of Health Homes services. However, the State would need to develop coverage, payment and evaluation methods to ensure that the Health Homes services do not duplicate ordinary nursing facility services. To the extent that Health Homes payments were made to nursing facilities, the State would need to ensure that the Health Homes payment was for services above the level of the services which the nursing facility was already obligated to furnish under the applicable nursing facility conditions of participation and the nursing facility payment rate. For example, the State might need to distinguish between normal nursing facility discharge planning and transitional care efforts that exceed the level of discharge planning.

What is member to nurse ratio?
At this point there is not one. In the development of the payment methodology, staff to member ratio will be considered.

What are the expected qualifications of care coordinators and case managers? How will they be trained to ensure consistency in care across KS?
Those are still being determined. It is expected that we will build on already established requirements for these professionals. Training will be provided by both the MCOs and the HH Partner agencies.

What Health Homes qualifications have been identified?
Please refer to the draft standards found here: http://www.kancare.ks.gov/download/KanCare_Health_Homes_Provider_Standards_Draft.pdf.
Additional professional qualifications will be published soon.

Are there limitations of what type of facility/organization can be the designated Health Homes? (ex. health care facility, community service provider, faith-based organization, state/local sub-programs, etc.)
Any Medicaid provider who can meet the HH standards and qualifications and who can provide one or more of the six core HH services is a potential HH Partner.

Will MCOs see the need for HHP to view data as a paid care management function? Even if they maintain and analyze the data? What about the need for coordinated team meetings with various HHPs?
HHPs will be paid a sub-capitation payment or PMPM by the MCOs; the HHP will not bill fee for service for each discrete core service provided. HHPs will likely not be meeting with each other, unless they also provide other service, e.g. behavioral health services covered by KanCare. Whether or not the MCOs will have meetings with their HHPs should be spelled out in the MCO-HHP contract.